VERMONT

DOL FORM 6 (Rev. 5/05)

State File No. _____

Ins. Co. File No. _____

Date of Injury _____

Fed. ID No. _____

DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION

NOTICE AND APPLICATION FOR HEARING

EMPLOYEE:

Name: _____

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____

Social Security Number: _____

EMPLOYER:

Name: _____

INSURANCE CARRIER:

Company Name: _____

Adjuster Name: _____

The accident upon which claim for compensation is based, occurred on the _____ day of _____, 20 _____

in the town of _____ and the state of _____.

Briefly state the issue(s) in dispute:

_____

_____

_____

THE APPLICANT SEEKS:

- ☐ Temporary Total Disability Compensation
- ☐ Temporary Partial Disability Compensation
- ☐ Permanent Partial Disability Compensation
- ☐ Permanent Total Disability Compensation
- ☐ Medical & Hospital Benefits
- ☐ Vocational Rehabilitation
- ☐ Dependency Benefits (Fatal Claim)
- ☐ Attorney's Fees

Attorney: _____ Law Firm: _____

Representing ☐ Employee ☐ Employer

_____ _____

Signature of Requesting Party Date